

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08135 209

1. PLACE OF DEATH:

County... Kent
 City or town... Chesportown, Ind
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 hours
 Hospital, institution, or street address where death occurred:
Kent and Queen Anne General Hospital
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Kent
 City or town... Chesportown, Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Haven
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Jerry Carl Ashley

3. (b) Social Security Number

4. Sex m. 5. Color or race wh 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife..... 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) August 21 1946

8. AGE: Years Months Days If less than one day
4 hrs. 20 min.

9. Birthplace... Chesportown, Ind
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name... Alvin B. Ashley13. Birthplace... Baltimore, Md14. Maiden name... Irene M. Peaty, wife15. Birthplace... Milton, Pa.16. Informant... Alvin AshleyAddress... Rock Hall, Ind.

17. Burial Date thereof Aug 22, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Westley Cem.Location... Rock Hall18. Funeral director... FamilyAddress... Rock Hall, Ind.

19. Aug 22 1946 Clara S. Barnes
 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Aug 21 19 46 at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-21-46 5:30 PM 19 46 to 8-21-46 9:50 PM 19 46
 and that I last saw him alive on 8-21-46 19 46

Immediate cause of death... Prematurity 6 m.

Due to... (Birth weight 6.53)

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Albert R. Burgard

Address... Rock Hall, Ind. Date signed... 8/22/46

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AUG 24 1946
BUREAU V.B.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County... Kent

City or town... Rock Hall
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Kent

City or town... Rock Hall Rural
(If outside city or town limits, write RURAL and give nearest town)Street No... Green Lane
(If rural, give LOCATION)

2. (a) If veteran, name war...

3. (a) FULL NAME

James Arthur Cannan

3. (b) Social Security Number

218-20-7183

4. Sex

M.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Marie Cannan

7. Birth date of deceased (mo., day, yr.)

May 19 1899

6. (c) If alive, give age... 40 years

8. AGE:

Years

47

Months

2

Days

28

If less than one day

hrs. min.

9. Birthplace

Rock Hall, Md.

(Town, county, and state)

10. Usual occupation

waterman

11. Industry or business

own

FATHER

12. Name

Arthur Gas Cannan

13. Birthplace

Cecil Co., Md.

MOTHER

14. Maiden name

Amanda Loggell

15. Birthplace

Kent Co., Md.

16. Informant

Marie Cannan

Address

Rock Hall, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

8/19/46
(month) (day) (year)

Cemetery or

Wesley Chapel

Location

Rock Hall, Md.

18. Funeral director

Edgar L. Lane

Address

Clumh Hill md

19.

8/19
(Date rec'd by registrar)

19. 46

S. Elwood Bingers
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... August 16 1946 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12 1945 to August 16 1946

and that I last saw him alive on August 16 1946

Immediate cause of death

chronic endocarditis
angina pectoris

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Albert A. Burgard

M. D. or other

Address

Rock Hall, Md.

Date signed 8/16/46

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AUG 28 1946

BUREAU 7 8

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

CERTIFICATE OF DEATH

08136



Reg. Dist. No. 202

1. PLACE OF DEATH: **Kent**
 County.....
 City or town..... **Chestertown**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **lifetime**
 Hospital, institution, or street address where death occurred:
Kent & Queen Anne County Hospital
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Md.** County..... **Kent**
 City or town..... **Chestertown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
J. Dudley Everett

3. (b) Social Security Number
223-03-5754

4. Sex **male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **Separated**

6. (b) Name of husband or wife..... **Helen West Everett**

7. Birth date of deceased (mo., day, yr.) **July 26, 1906** 6. (c) If alive, give age..... years

8. AGE: Years **40** Months **I** Days **2** If less than one day..... hrs. min.

9. Birthplace..... **Kent Co. Maryland**
 (Town, county, and state)

10. Usual occupation..... **Electric Light Co.**

11. Industry or business.....

12. Name..... **James Everett**

13. Birthplace..... **Maryland**

14. Maiden name..... **Mamie Waller**

15. Birthplace..... **Maryland**

16. Informant..... **Mrs. Emory Newton (sister)**
 Address..... **Chestertown, Md.**

17. Burial..... **Burial** Date thereof..... **Aug. 30, 1946**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... **Chester Cem.**
 Location..... **Chestertown, Md.**

18. Funeral director..... **J. Willis Wells**
 Address..... **Chestertown, Md.**

19. **Aug. 31** 19. **46** **Clara S. Barnes**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
 2D. DATE OF DEATH..... **Aug 28** 19. **46** at **1 P** M

21. CERTIFY that death occurred on the date above stated; that he died from..... **Aug 13** 19. **46** to..... **Aug 28** 19. **46**
 and that he last saw him..... **Aug 28** 19. **46**

Immediate cause of death..... **Postoperative Respiratory & Circulatory Failure**
 Due to..... **Anesthesia + operative shock**

Due to..... **Compound Bilateral Fracture of the Jaw**
 (Include pregnancy within 3 months of death)

Major findings of operations..... **Aug 28 46**
 Date of op.....

Autopsy results..... **None**
 PHYSICIAN: Please underline the cause to which death should be charged medically.

22. UNDERLINE the cause to which death should be charged medically..... **This man was struck in jaw by**

an automobile. Individual fracturing

of the jaw. Cause of death

in which he died (on street)

Struck in jaw Injured at work? **no**

Investigated by Deputy Med. Ex. **Dr. J. Willis Wells**
 M.D. or other
 Address..... **Chestertown, Md.** Date signed..... **Aug 28/46**

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SEP 2 1946
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County...
City or town...
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death...
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State...
County...
City or town...
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)
2. (a) If veteran, name war...

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex
5. Color or race
6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
hrs. min.

9. Birthplace
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial Date thereof

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Aug. 30, 1946

(Date read by registrar)

Clara S. Barnes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19, 1946 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from...
and that I last saw him...
Immediate cause of death...
CORONER

22. Cause of death
Due to...

Due to...
Other conditions...
(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

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AUG 24 1946
BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent

City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
Kent & Queen Anne Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Chestertown - rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Howard J. Reed

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ida C. Reed

6. (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 11-12-1889

8. AGE: Years 56 Months 9 Days - It less than one day _____ hrs. _____ min.

9. Birthplace Watson Kent County, Md.
(Town, county, and state)

10. Usual occupation Postal Clerk

11. Industry or business U.S. Postoffice

12. Name William E. Reed

13. Birthplace Kent County, Md.

14. Maiden name Margaret Matthews

15. Birthplace Kent County, Md.

16. Informant Ida C. Reed - wife

Address Chestertown, Md. R.F.D.

17. Burial Date thereof 8-14-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chester

Location Chestertown, Md.

18. Funeral director J. Willis Wells

Address Chestertown, Md.

19. Aug. 13 19 46 Clara S. Barnes
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 46 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Aug 12 19 46

and that I last saw him alive on Aug 12 19 46

Immediate cause of death _____ DURATION _____

Chronic Nephritis 3 yrs

Due to _____

Malignant Hypertension 4 yrs

Due to _____

Other conditions Arteriosclerosis 4 yrs

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank Smith M. D. or other _____

Address Chestertown, Md. Date signed Aug 14

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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AUG 15 1946
BUREAU VS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

08140

Reg. Dist. No. 202

1. PLACE OF DEATH:
County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lifetime
Hospital, institution, or street address where death occurred:
Cannon St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

Amanda L. Walker

3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Geo. W. Walker

7. Birth date of deceased (mo., day, yr.) June 28, 1863 6. (c) If alive, give age _____ years

8. AGE: Years 83 Months I Days IO If less than one day _____ hrs. _____ min.

9. Birthplace Kent Co. Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Abraham Stanley

13. Birthplace Maryland

14. Maiden name Sarah Furrell

15. Birthplace Maryland

16. Informant Mrs. John A. Kennard (neice)

Address Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug. 11, 1946
(month) (day) (year)

Cemetery or crematory Chester Cem.

Location Chestertown, Md.

18. Funeral director J. Willis Wells

Address Chestertown, Md.

19. Aug. 10, 1946 Class L. Barnes
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 19 46, at 6 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 8 to Aug 8 19 46
and that I last saw him alive on Aug 8 19 46

Immediate cause of death Cerebral hemorrhage

Due to Arterio Sclerosis

Due to hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____

Where did injury occur? none
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury stroke Injured at work? _____

23. SIGNATURE David H. Jones M.D. M.D. or other _____

Address Chestertown Md Date signed Aug 9/46

MARGIN RESERVED FOR BINDING

VS A15

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RECEIVED

AUG 13 1946

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